

*Printed Patient Name: _____	*Date of Birth: _____
*Address: _____	*Telephone Number: _____
*City: _____ *State: _____ *Zip Code: _____	(____) _____

*I hereby authorize _____ to release and exchange written, oral or electronically transmitted (facility name) protected health information indicated below on the above named individual to:

* _____
 Provider Name/Organization/Individual

* _____
 Full address of Provider/Organization/Individual

*City: _____ *State: _____ *Zip Code: _____ *Telephone #: (____) _____

*Including information related to: Psychiatric Care & Treatment Substance Abuse Care & Treatment Medical Care & Treatment

*For the following purpose: Physician or Health Care Facility Legal Purposes Personal Use Follow-up Care Tuition Payment School Staffing
 Placement Insurance Determination Vocational Service Referral Continuity of Care At Request of the Individual
 Primary Care Physician Other(Specify) _____

*Treatment date(s): _____ *Date Authorization Expires: _____
Treatment Date(s) must include month and/or year (1 year maximum)

***INFORMATION TO BE DISCLOSED:**

<input type="checkbox"/> Dates of Admission & Discharge	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Speech & Language Eval.	<input type="checkbox"/> Attendance
<input type="checkbox"/> Face Sheet	<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Medication Information
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Psychiatric Diagnosis
<input type="checkbox"/> Physical Health Screen	<input type="checkbox"/> Psychosocial Assessment	<input type="checkbox"/> Treatment Update	<input type="checkbox"/> Treatment Information
<input type="checkbox"/> Consultation	<input type="checkbox"/> Level of Care Screening	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Follow-up care
<input type="checkbox"/> Admission Assessment	<input type="checkbox"/> Other (Specify) _____		<input type="checkbox"/> Chemical Dependency Diagnosis
<input type="checkbox"/> HIV Documentation _____ (Must Initial)			<input type="checkbox"/> Medical Conditions and / or Diagnosis
			<input type="checkbox"/> Homework information
			<input type="checkbox"/> IEP or 504 Plan Information
			<input type="checkbox"/> School Information Form

Work Letter MAY Disclose Treatment Type and Facility _____ (Must Initial)
Work Letter MAY NOT Disclose Treatment Type and Facility _____ (Must Initial)
WORK LETTERS ARE NOT TO BE FAXED THEY MUST BE PICKED UP BY PATIENT

I understand that:

- **The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).**
- I have the right of access to inspect and obtain a copy of my protected health information.
- I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department.
- Revocation will not apply to information that has already been released in response to this authorization.
- Re-disclosure is prohibited unless the person who consented to the disclosure specifically consents to re-disclosure. However, once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy laws regulations.
- Failure to provide all required information will not constitute a proper authorization to disclose protected health information and that, therefore, my request may not be honored.
- Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment, payment or eligibility for benefits.
- **The Consequences of my refusal to sign, if any are:** _____

_____ * (Signature of patient) _____ * (Date) _____ (Signature Parent or Legal Representative) _____ (Date)
 (Patients 12 to 17 years of age must sign in addition to the Parent or Legal/Personal Representative)

_____ * (Witness Signature) _____ * (Date)

(If signed by a legal representative, indicate the relationship to patient or authority to act for patient.)
 Fees/charges will comply with all laws and regulations applicable to release protected health information.

FOR FACILITY USE: Date received: _____ Date completed: _____ MR #: _____

When applicable, the identity of the Legal Representative was verified by the following documentation and established that in his/her capacity, the above named legal representative is authorized to act on behalf of the patient: Driver's License Picture ID Legal guardian Court appointed legal guardian
 Power of Attorney Executor of Estate Other: _____

Person/Department completing the request: _____

